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CASE OF PELVIC CELLULITIS.

[Reported to the Boston Society for Medical Improvement, Nov 23d, 1863, and communicated for the Boston Medical and Surgical Journal.]

By W. C. B. Fifield, M.D., Dorchester.

During the night of Saturday, Aug. 22d, 1863, I attended Mrs. C., aged 23, in her first confinement. She was delivered of a female child after an easy labor of about six hours. Mrs. C. remained quite comfortable until the 25th, although somewhat teased by her inability to nurse the child satisfactorily, her nipples being quite flat. As the breasts were distended and hot, a saline purge was ordered with good effect. On the 27th, owing to my illness, she was visited by Dr. Cushing, to whom she complained of pain in the right groin. A ginger poultice was ordered, with relief to the pain. On Sunday, the 30th, I visited her, and found her complaining of dull pain in the groin, with tenderness on pressure, and inability to extend the right thigh and leg without pain. The child had sickened, and in a few days it died, as it seemed, from being unable to extract sufficient nutriment from the mother's breasts. At my visit, Sept. 2d, the patient still complaining of pain in the groin, a dozen leeches were applied, with complete relief to the pain, the inability to completely extend the leg without pain remaining. From this time till the 15th of September, she remained tolerably comfortable, with the exception of occasional diarrhœa, which was checked by appropriate remedies.

At this time the pain returned in the groin with some severity, extending nearly to the lumbar vertebræ. Upon deep pressure, a long, hard tumor could be detected, commencing near Poupart's ligament, and rising above the crest of the ilium. It seemed to fill the space between that process and the last ribs. The patient complained of night sweats. Pulse 112, feeble. No appetite. The thigh was flexed on the pelvis, and could scarcely be extended, even to a slight degree, without great pain. It was especially painful and difficult for the patient to attempt to gain an erect position, as in getting out of bed, which was seldom done. No tumor could be detected by vaginal examination. A large blister was ordered to be applied to the whole of the tumor; morphia, to procure sleep at night; acid. sulph. aromat., gtt. xx., thrice daily; nourishing diet.

16th.—Pain in flank and groin entirely relieved, but patient complains of most violent strangury, for the relief of which laudanum and starch injections were ordered, with diluent drinks of gum Arabic, flaxseed, slippery elm, &c.

17th.—No relief of strangury, which is quite distressing. Catheter passed, relieving patient for nearly two hours, when the strangury returned with violence. Laudanum injection.

18th.—Strangury remaining much the same, I ordered the following mixture, in teaspoonful doses, three times a day: ℞. Bal. copaibæ, spts. nit. dul., aa ℥ i.; muc. gum. acacia, ℥ i.; spts. lavend. com., ℥ ss. M.

19th.—Strangury relieved.

From this date until Oct. 1st, no severe pain in the groin was complained of, except on pressure, though the thigh could not be extended. The tumor became better defined, but gave no signs of approaching the surface. Friction with ointments, particularly of the iodide of lead, was used. Nourishing diet. Porter and wine freely given. Morphia at night. The pulse remained rapid and feeble. Appetite very deficient. The patient remained confined to the bed, rising once or twice daily. Vaginal examinations detected no tumor.

Oct. 1st.—My patient had risen from bed and lain upon the lounge for a few minutes, when she told her mother that her monthly turns had come back profusely. Examination showed the underclothes drenched with matter, and pus flowing from the vagina. All pain ceased, and a raging appetite appeared. Convalescence progressed steadily until the 11th of October, when she again complained of violent strangury, the urine showing a plentiful deposit of pus. A catheter being passed, several spoonfuls of pure pus flowed from its extremity, showing, I think, conclusively, that the abscess had burst into the bladder. Pulse rapid, and only detected by the most attentive examination. The former mixture ordered. Brandy and porter freely given. Good diet. The strangury passed away gradually; strength returned, and on the 18th she was removed in a carriage to Pawtucket. She has since returned to Dorchester, I believe in very good health.

The best practical essay with which I am acquainted, on the subject of pelvic cellulitis, is contained in a very valuable book entitled "Clinical Memoirs on Diseases of Women and Children," by Dr. McClintock, late Master of the Dublin Lying-in Hospital. A short *résumé* of the results of his experience may be acceptable to those who have not seen it. In regard to the seat of the disease, says Dr. McClintock, "it may affect almost any part of the cellular tissue adjacent to the uterus; in the broad ligament, in the iliac fossa, between the bladder and abdominal parietes, or between the uterus and rectum. Sometimes the tumor extends considerably above the crest of the ilium, and at others is only discoverable by vaginal examination." Though sometimes very exhausting to the patient's strength, and always tedious in its progress, still the disease seldom ends fatally (referring to cases following confinement). Of seventy cases under his care, but two so terminated, and in each of these the immediate cause of death was dysentery, in consequence of the abscess bursting into the colon. The complaint is a more common sequence of first than of subsequent labors. Of sixty-one cases, twenty-eight were primiparous women. Whether a primary or secondary affection, it seldom makes its appearance after the month of childbed is passed over. The sex of the child, age of the woman, whether she suckles or does not suckle, have, in Dr. Mc Clintock's opinion, no influence on its production, who thus differs from M. Grisolle and Dr. Bennet, who state that "one of its most frequent causes is the sudden arrest of lactation, however it may originate." In most cases the tumor is discoverable by external examination, but in others, though no tumor can be felt externally, yet internal examination reveals the existence of tumefaction adjoining the cervix. The duration may extend over weeks and months, and is divided by Dr. McC. into three stages: "The *acute*, marked by hot, dry skin, furred tongue, thirst, frequent pulse—100 to 120—with hypogastric pain and tenderness. The *sub-acute* or *chronic*, when the fever has abated, the pulse 90 or 96 and the pain nearly subsided, the patient weak and languid, no appetite, night sweats. Little pain is felt when at rest, but when pressure is made, morbid sensibility exists. Inability to extend the thigh of the affected side is a symptom occasionally present, and is a source of much annoyance. It is most remarkable when the patient is on her feet, for then not only is the thigh flexed, but the trunk is bent forward. When she is in bed and lying on the side affected, she finds that she can with the least pain stretch down the thigh." Our author agrees with Churchill that when this is present, the sub-serous cellular tissue covering the psoas and iliacus muscles is engaged. He ranks it among the unfavorable prognostics of the disease, as cases where it was present were among the worst, all ending in suppuration, and one fatally. The disease may become entirely chronic, the tumor hard, well defined, and, if large and extending above the crest of the ilium, may be mistaken for an ovarian tumor. It may now terminate in resolution or suppuration. If the latter, there is a return of pain, great increase of tenderness, acceleration of pulse, anorexia, emaciation, chills and night sweats. If this stage be long continued, the patient may be reduced to a state of great marasmus, from which recovery would seem impossible. Suppuration having been established, pointing may take place, 1st, externally in *(a)* the iliac, *(b)* the inguinal (below Poupart's ligament), *(c)* the supra-pubic, or *(d)* the perineal region; 2d, it may burst into the colon or rectum; 3d, into the vagina; or, 4th, into the bladder. He has never known a puerperal pelvic abscess to burst into the peritoneum. Of the frequency of abscess in puerperal pelvic cellulitis, the clinical records show the following results. Of seventy cases, thirty-seven ended in suppuration. Twenty-four of these burst or were opened externally; twenty in the iliac region, two above the pubes, one in the inguinal region, one beside the anus, six per vaginam, five by the anus, and two by the bladder. In regard to vent being had externally or internally, Dr. McC. believes that the former terminate more favorably, though he differs from other writers.

M. Becquerel, one of the latest, says: "The opening which takes place directly external is in general a circumstance more hurtful than the opening into an organ communicating with the exterior, the suppuration goes on longer, weakens the patient more, and is more frequently complicated with alteration of pus and with putrid infection." In regard to return of the catamenia, it is not to be expected during the active continuance of the disease. It has occasionally come on towards the close of the chronic stage, and is then to be esteemed a most favorable symptom. The cases in which it occurred all ended in recovery, and had no relapse. Of the influence which pelvic cellulitis may have on the capability of the patient to bear children, or cause future labors to be difficult or badly recovered from, the author believes it to be null. Of seventy cases, nineteen became pregnant, some once, twice and three times afterwards. All went the full time, had good labors, and with one exception recovered favorably. Two of these women had had cellulitis ending in abscess discharged externally, or into the vagina, rectum or bladder. In regard to opening these abscesses, the author says that if they point externally, an artificial opening should be made, but not until the matter is near the surface. It is not necessary to wait until the skin becomes adherent to the tumor, though advisable. If the abscess tend towards the vagina, is prominent, distinctly fluctuating, and causing much distress, the bistoury may be used. But in the ordinary run of cases, it is better to let it burst of itself when pointing in this situation. Dr. West says:—"The attempt to anticipate by puncture the exact route the pus may take, is frequently unsuccessful and not always safe."

THE operation of ligature of the subclavian artery was performed on the 20th ult., for axillary aneurism, by Dr. Armsby, of Albany. The latest accounts state the results to be thus far favorable, with every prospect of a successful issue.

PRESERVATION OF CARIOUS TEETH BY FILLING.

[Read before the Suffolk District Medical Society, November 28th, 1863, and communicated for the Boston Medical and Surgical Journal.]

By Enoch C. Rolfe, M.D.

It is to be feared that in the abundance, cheapness and beauty of artificial dentures, the importance of preserving the natural teeth will be overlooked. There is a large class of dentists who pay little or no attention to dental surgery. They have devoted a few months to learning to make artificial work, and to extract teeth—or break them off—and this is the extent of their knowledge of dentistry. If a tooth is painful they advise its removal at once.

Physicians too often lend their sanction to this method of disposing of diseased teeth. They are constantly meeting patients suffering with neuralgic and other nervous diseases, resulting from decayed teeth. They know that removing them will cure the neuralgia, and they order their removal, without stopping to consider whether restoring health to the teeth would not as effectually cure the neuralgia, and at the same time save the patient the loss of these important organs or the necessity of wearing artificial teeth. It is perfectly surprising to see how indifferent most persons are to the loss of teeth. I think not more than one in ten expresses any regret at it. People dread being hurt, and the fear of being hurt makes them dread having out a tooth. But tell them that it is a great misfortune to lose a good tooth, and they seem surprised, and very often say, "Why, I wish they were all out, and then I could have a new set, handsomer than these."

Just now the nitrous oxide epidemic is causing the loss of thousands of teeth that there is no more necessity for losing than there is for the loss of a finger with whitlow or a foot with chilblain. I admit, with pleasure and pride, that artificial dentures are now so perfectly made in this country that, in many respects, art rivals nature; and in fitting a good set of artificial teeth to a mouth that for years has not known sound teeth, or sweet breath, or comfortable mastication, I feel that the dentist is doing as much for humanity as the surgeon who breaks up the adhesions of a stiffened joint. And yet artificial teeth, as a whole, fall as far short of good natural ones as a "Palmer leg" falls short of a good natural limb; and the loss of a tooth should be treated by doctors and dentists as a calamity to be avoided by all the skill they can command. Bad teeth should be restored to health, or removed. My purpose, however, in the present paper, is only to call attention to two forms of disease, or decay, frequently met with, and too frequently, as I believe, treated by removing the teeth.

The first is where the dental nerve is involved in the decay, but still sensitive, or where the nerve is completely dead; the second, where a tooth has lost a portion of its crown or cutting surface by extensive decay, and may or may not have the nerve exposed. It does not follow that a tooth must go on decaying until there is no remedy but removal, merely because the nerve is exposed or destroyed. I know many a useful tooth that has had no dental nerve for ten, twelve or twenty years. To effectually prevent the destruction of such a tooth it is necessary that all the decay should be removed and the nerve cavity well and securely filled, so as to keep out all moisture. A tooth thus treated is almost as certain to last for years, as it would be if the same decay had existed and the cavity had been filled in the crown without the nerve having been exposed; but to destroy a nerve, and then fill the crown, without first plugging the nerve cavity, is to leave a closed cavity in the fang, where moisture or pus may collect and produce severe pain. Sometimes this will follow the operation immediately; at other times it will come on after years of entire ease. I have recently seen both these conditions illustrated. A gentleman came to me complaining of great pain in an upper molar tooth. On examination, I found that it had a large gold filling in it, but was otherwise a healthy-looking tooth. He stated that just a week previous he had been to another dentist, and had the nerve of this tooth killed and the cavity then filled; that immediately after, it commenced aching, and had not been easy for an hour, hardly for a moment, up to the time of his visiting me. As I could see no other explanation of the pain, I expressed my fears that the nerve-cavity had not been plugged. He said the dentist who filled the tooth told him that he filled the root, and made an extra charge for it. I advised him to have the filling removed and have it tried again, but at this he seemed angry, accused me of a desire to get a fee out of him without doing him any good, as the other dentist had done, and said several things not complimentary to dentists generally. This left me no alternative but to remove the tooth. On examination, I found one fang quite black, and upon inserting a small probe into it, pus was forced out, but no gold was found. I was satisfied, and the patient professed to be, that if the nerve-cavity had been well plugged at first, his tooth would have done well, or that if he had followed my advice and had the filling removed, it might have been saved.

Another man called about the same time, complaining of severe pain in a tooth that had been filled about five years before, with amalgam. The nerve had been killed, but the nerve-cavity had not been filled. Until within a week, he said, he had not had the slightest trouble with it; the tooth had felt as well and been as useful as any tooth in his head. On removal, the fangs were found blackened and filled with pus.

The simplest method of destroying a nerve is to apply a minute quantity of arsenical paste, composed of equal parts, by bulk, of arsenic and sulphate of morphia reduced to a creamy paste with creasote. A bit of cotton as large as a millet seed, saturated with this paste and placed in contact with the exposed end of the nerve, will destroy it in from four to twelve hours. With children and young persons, four hours is long enough. As soon as the cautery is complete, the cotton should be removed and the cavity well rinsed with warm water. After a day or two the dead nerve should be removed, and if there is no soreness in the tooth or gum, the nerve-cavity may at once be plugged. It should be filled to as near the end of the fang as possible, and with gold. It is almost impossible to get anything but gold in, unless the nerve has been a long time dead and the cavity has become enlarged by decay. The best dentists recommend filling nerve-cavities with gold, even where the crown is to be filled with amalgam. After filling the fang to the floor of the crown-cavity, it is often desirable to wait for a few days before completing the operation, particularly where the teeth are sensitive, or where alveolar abscess has ever existed. So much and so long pressure at one time would be very likely to bring on inflammation, and perhaps suppuration. Two or three days after, or a week if very tender, the crown may be filled with less danger. Where there is no danger of inflammation, I am in the habit of doing the whole operation at one sitting. In this way I have saved many teeth that were brought for extraction. In not a few of the cases the patient has had so little faith in the operation that I have been obliged to refuse to extract before consent could be obtained to make trial of saving the tooth; and yet with all this want of faith, less than one case in twenty fails, where the treatment has been, as I have described, with gold. Unfortunately for themselves, and for the success of these operations, many persons, some from poverty, others from meaner motives, cannot or will not pay for gold, but are willing to try the experiment with amalgam or some other cheap filling. I never fill a good tooth with anything but gold, without first saying all that the circumstances will warrant against it; but rather than extract such a tooth I sometimes use tin, amalgam, or the oxy-chloride of zinc. As the nerve-cavity cannot be filled with any of these, it leaves the same liability to inflame and suppurate that I have before mentioned. Yet with all this liability, more than half the cases so treated for the last five years have not given the patient trouble.

Of all the cheap fillings, I prefer amalgam where the tooth is so far out of sight that the color is not an objection. The American Dental Association, some years ago, passed resolutions against the use of amalgam, but a year or two subsequently these resolutions were repealed. It is much better to save a tooth, even for a year or two, with amalgam, than to lose it, particularly where mastication depends upon it, as is quite often the case.

[To be continued.]

THE NORMAL AND PATHOLOGICAL HISTOLOGY OF THE KIDNEYS.

By V. Rasmussen.

Passing over the normal histology, which the author goes into at considerable length, of the renal vessels, the renal parenchyma, and the interstitial connective tissue, we proceed to notice the pathological changes in the kidneys referable to the term "Morbus Brightii," as they are described.

The author prefaces his remarks on this subject by observing—"In studying renal diseases, the object of our investigation is to establish the three following points:—1. What tissue or tissues are affected (vessels, parenchyma, or interstitial connective tissue); 2. Whether only the cortical substance or the pyramids are attacked, or both together; and, lastly, 3. Whether the affection is partial or diffused. In the commencement a definite tissue can always be indicated as the starting-point of the affection; later this is most frequently not possible; the several tissues are dependent on each each other, so that they are often consecutively attacked; but, on the other hand, the several lobuli possess also independence of each other, and we have already seen that the vascular system of the cortical substance and that of the pyramids are to a certain extent independent of one another. It is especially chronic affections of the kidney which will be the subject of our consideration in an anatomico-pathological point of view. Formerly these were comprised under the name of 'Morbus Brightii,' but this is a very inaccurate denomination, and one which conveys but little information. The older investigators properly included under this term only what we now call parenchymatous nephritis, whose terminal stage is the characteristic and striking granular atrophy. Although this form is by far the most frequent, modern researches have revealed other pathological changes in the kidneys, which clinical physicians have not yet succeeded in definitely diagnosticating from the parenchymatous nephritis; and it becomes, therefore, necessary to refer to these also the designation 'Morbus Brightii,' so far as such a name shall be retained as a common denomination for these extremely different conditions. The essential symptoms are the albuminuria and the diminished secretion of urine, while the so-called fibrin cylinders have not the signification which Frerichs ascribes to them; they occur, at all events, only in the parenchymatous nephritis, and not even constantly in that. Here are three essentially different affections to be considered, each occupying its own tissue—1. The amyloid degeneration of the kidney; 2. The parenchymatous; and 3. The interstitial nephritis. They may complicate one another; nay, all three may be present at once; sometimes one, sometimes another occurs first, but the parenchymatous is most frequently the primary affection.

Rasmussen then proceeds to consider the above-named three affections.

The amyloid degeneration can only *very rarely* be recognized without having recourse to the chemical reaction (*i. e.*, by the microscope alone), owing to the limitation of the disease to the vessels, to the exclusion of the parenchyma, and also to the fact that the disease is most frequently combined with parenchymatous or interstitial nephritis, or the interstitial fatty kidney, especially in people who have died from the discrasia of syphilis or of the mercury by which it may have been treated. The author observes, that in the amyloid kidney we may or may not have a lardaceous or waxy appearance, that in very extreme cases of degeneration we may almost certainly detect this amyloid condition by the glomeruli assuming a whitish-grey, shining, enlarged, and prominent character, which appearance is also assumed by the "vasa afferentia," and other neighboring arteries. As regards the vessels which are affected, it is asserted to be the small vessels, and in this order: "first and foremost, the glomeruli and vasa afferentia, next the vasa efferentia and the capillaries in the cortical part, and, finally, the 'arteriolæ rectæ'"; rarely are the large vessels affected, and it is long before other tissues become so.

Owing to the peculiar deposit affecting the vessels and glomeruli, the supply of blood becomes diminished, the cortical substance anæmic, while the hyperæmia increases in the pyramids, and hæmorrhage occurs at times, owing to increased pressure on the inelastic vascular walls, giving rise to reddish or brownish streaks or spots. This thickening of the vessels, &c., from amyloid, is not to be confounded with the thickening which results from a change corresponding to the "so-called end-arteritis," by which organization of newly-formed elements and subsequent atheromatous and fatty degeneration is produced, chiefly, indeed, in the larger vessels, but at times affecting the glomeruli. This fatty degeneration commences with an increase of nuclei of the capillaries, which divide, become separated, and thus elongate the loops in the glomeruli without increasing their calibre. If the process advances, small fatty particles accumulate around the nuclei, and increase with disappearance of the nuclei. Thus a whole glomerulus may degenerate, and the same result be produced as if we had amyloid degeneration. Such a fatty degeneration of the glomeruli may, microscopically, simulate amyloid, but the reaction and microscopic appearances soon discover the difference. The author gives in detail the best method of obtaining the chemical reaction of amyloid.

As respects the "*parenchymatous nephritis*," the author, after alluding to the relation of the epithelium of the renal canals to the urine, and to the fact that the cells in the convoluted tubes are larger and richer in albumen than those in the straight ones, points out that any disease of the former rendering them inactive will be of more serious import than disease of the latter, producing an actual change in the urine; and in consequence of this distinction he establishes two forms of parenchymatous nephritis, the "papillary catarrh," or catarrhal nephritis, and the *proper* parenchymatous nephritis.

The *Papillary Catarrh*, situated in the straight canals and papillæ, and comparable to the bronchial catarrh, is often continued from the bladder or urethra, but may be caused by external agents, as the use of cantharides, acid diuretics, and alcoholic drinks. It is often complicated with parenchymatous nephritis, and may be the starting-point for it. *Post-mortem* examination shows the affected canals and papillæ to be attended by a whitish or yellowish striation, with hyperæmia of intervening vessels; and when the disease is owing to internal remedies, hyperæmia and bloody ecchymosis over the whole kidney exist. If the disease continues long, the distended urinary canals press on the bloodvessels, and thus the hyperæmia ceases. The disease is mostly limited to an abundant and varied production of cell-growth (nucleated, club-shaped, or fusiform, and, it may be, ramifying), mixed with mucous catarrhal products; but a process may exist, as in the acute forms, like that of the proper parenchymatous nephritis, with fatty metamorphosis and destruction of epithelium.

The *proper Parenchymatous Nephritis* is described (after Virchow) as an hypertrophy of the cells of the convoluted canals, which take up large quantities of the albuminates, become distended, turbid, granular, and adhere closely together; subsequently the cells vanish, and the granular fatty mass becomes free, forming the "inflammatory globules." The author describes three stages of the affection (which he parallels with pneumonia), which may all be going on simultaneously, and delineates the anatomical characteristics of each one. This affection often co-exists at a later stage with intestinal nephritis. In the second stage (that which, when papillary catarrh exists, as nearly as possible constitutes " Bright's kidney "), the retardation of the venous blood is described, and the consequent thrombus, and the continuation thereof to the vena cava and heart, and also transmission into the lungs. The third stage described is, in fact, a resolution or recovery, and corresponds to the complete fatty metamorphosis of the cells, generally, but not always, with loss of substance, induration, granulation, and formation of cysts in connection with the urinary canals. The interspaces between the granular elevations of the surface are ascribed to the empty collapsed canals, which, owing to their pressure on the vessels having ceased, are often of a reddish color; and the author points out that this granular atrophy is not analogous to cirrhosis of the liver, inasmuch as it is the parenchyma itself which is first affected, and only subsequently complicated with intestinal nephritis; whereas in the case of the liver it is not the hepatic cells which are first affected, but the inter-acinous connective-tissue. In the third stage the glomeruli are described as generally small, corrugated, surrounded by thickened capsules of connective-tissue, and possibly (as also the epithelium) in a fatty state, sometimes amyloid, and sometimes calcareous.

In the *interstitial nephritis*, the change in the interstitial connective-tissue may preferentially affect the intercellular substance, which becomes hypertrophied, whilst the cells only become slightly increased in number, though they become larger, or the cells may multiply by frequent subdivision, whilst the intercellular substance is not much increased; and if this condition is very extreme, suppuration is the consequence. A third but rarer result is the interstitial fatty kidney, when the newly-formed connective-tissue passes into fatty degeneration. In the first and lower degrees of the second form, the connective-tissue contracts around the canals and glomeruli, and the circulation is more or less obstructed; the interspaces become increased, the urinary canals slender and sometimes constricted in a bead-like manner, and the tunica propria is often thickened and streaked; and the glomeruli are seen small, homogeneous, and in a more or less fatty state. Other interstitial changes, which might be mistaken for the above, may arise from venous stages in the kidneys, in diseases of the heart, or from increase of the capillary nuclei, which may be mistaken for the nuclei of connective-tissue. The author specially mentions a form of interstitial nephritis affecting the pyramids, or circumscribed (syphilitic), in which depressions and cicatrices form not unlike those from hæmorrhagic infarctions.

In the *interstitial fatty kidney* (which is rare) the organ is large and flaccid, and is full of yellowish or whitish striæ and marks, and there is often amyloid or parenchymatous nephritis; the urinary canals are of diminished calibre, and separated far by fatty masses; the glomeruli, and generally the walls of the vascular cells are fatty or amyloid.

As respects the albuminuria of chronic renal affections, the author supposes that the albumen is transuded from the intestinal capillary net-work, owing to the increased lateral pressure, as especially when the afflux of blood is arrested; for example, when the renal vein is tied. He supposes, however, that to a certain degree the albumen may be eliminated in the glomeruli or from the large albumen-holding epithelial cells.

Other so-called *fibrin cylinders* are not to be looked on as an inflammatory product. Their origin is obscure, being found chiefly in the straight tubes and the pyramids, more rarely in those of the cortex, and scarcely at all in its convoluted tubes; also often in the constrictions and small cysts. They scarcely ever consist of fibrin, but are analogous to the so-called colloid mass. Those occurring in papillary catarrhs are formed of mucin. The author seems inclined to look on these cylinders (with Key and Virchow) as dependent on changes in the albumen of the epithelial cells.—*Edinburgh Med. Journal*, from *British and Foreign Medico-Chirurgical Review.*

THE LATE PROF. CHARLES HOOKER, OF NEW HAVEN, ON DIET.

[From an Inaugural Address by Prof. LEONARD J. SANFORD, M.D.]

IT was our friend's custom to devote a few lectures of each recurring course to the consideration of certain topics in medicine and surgery, upon which he entertained peculiar views; and to some of these, on account of their value, as also to show the working of his mind, we shall now refer.

The subject of diet was foremost amongst them, and, in discoursing upon it, he maintained that everybody, whether well or sick, should eat three meals a day, which should be about six hours apart, and taken at corresponding hours, daily; the food to be plain, nutritious, mainly solid, and to some extent consisting of fat meat. In sickness, if the stomach was irritable or the disease under which the patient was suffering was of a sthenic type, he would perhaps omit the use of meat and allow a less quantity of the unstimulating articles of food than the person was accustomed to use in health, but the regular intervals must still be adhered to, and the food must always be mainly solid. A sloppy diet he regarded as bad for a well person, and much worse for one who is sick. In a case where most physicians would direct gruel, animal extracts and jellies, to be used in small quantities at short intervals, he would order crackers or crusts and meat, which were only allowed at the regular meal times, and then, in such quantity as could be conveniently borne. If this allowance did not at once supply all the support which the patient required, he would make up the deficiency by a more bracing medication; but he contended that, by perseverance, a healthy appetite could ordinarily be soon reëstablished, which would render an entire discontinuance of medicine safe at an earlier period than would be possible under the other system of dietetics—in other words, the case would be sooner and more perfectly cured, and with less medicine, with the solid diet, than it could be if slops were fed to the patient. This regimen, it must be admitted, proved very successful in Dr. Hooker's hands; his best results from it were in cases of typhoid fever.

But, in the use of aliments, his strongest leanings were towards fat meat; he recommended it to all well persons, as being indispensable to the preservation of health, and insisted on its employment, as the stomach would bear, in all chronic cachectic cases. In the latter, it was a *sine qua non* to recovery, and so he was inflexible in directing its use. A question which he was sure to put to every walking case of sickness that applied for his assistance was, "do you eat fat meat?" and in prescribing for such patients he would sooner have dispensed with medicine than omitted the fat meat, provided, always, that the stomach could be brought to tolerate it.

It is not strange that our friend should have been pertinacious on this point, for a long course of observations extending over a large region of country, had enabled him to establish the following conclusions:—

I. "Of all persons between the ages of fifteen and twenty-two years, more than one fifth eat no fat meat.

II. "Of persons at the age of forty-five (at which time, and for several years after, the health is generally most uniform and sound) all, excepting less than one in fifty, habitually use fat meat.

III. "Of persons who, between the ages of fifteen and twenty-two, avoid fat meat, a few acquire an appetite for it and live to a good old age, while the great proportion die with phthisis before forty-five.

IV. "Of persons dying with phthisis, between the ages of fifteen and forty-five, nine tenths, at least, have never used fat meat."

When Dr. Hooker's broad views on the subject of oily food were first announced, the profession was startled, and so unplausible did they seem that we have been slow in putting them to the test; but so far as the trial has been fairly made, results favor the conclusions at which he arrived, and I cannot resist the conviction that the time is coming when the profession generally will conform, more or less closely, to this dietetic practice.

From what has already been stated, it will be inferred that Dr. Hooker regarded temperance in the use of fluids as essential to the preservation of health. He held that their excessive use weakened the stomach and gave rise to indigestion, and dyspepsia with all its train of evils; also, that the functions of the liver were deranged thereby, and further, that the blood becoming dilute, the individual was predisposed to dropsy and hæmorrhage, and to a variety of diseases incident to defective nutrition; and, moreover, he believed that intemperance in the use of alcoholic stimulants, in some instances, was excited by copious water-drinking. It is a well-known fact that the more a person drinks (beyond a certain quantity) the more he will desire to drink, the explanation of which is, that the water, by diminishing the secretion of the saliva, and washing away from the mouth and fauces the small quantity which is secreted, causes those parts to become dry—the individual of course experiences thirst, and finding no permanent relief from a recurrence to water (which is not strange, for the cause of any suffering can seldom accomplish its cure), naturally enough resorts to something stronger; the alcoholics are tried, their use is persevered in, and ere the victim is aware, he is possessed of an irresistible appetite for liquor. Thus does water drinking lead to rum drinking, according to Dr. Hooker, and the explanation is not merely a theory, it has foundation in fact, for he could cite illustrative cases which he *knew* were applicable. He considered a quart of liquids in the twenty-four hours as an outside allowance for any person, without regard to the season of the year; they were to be used only with the meals, and in about equally-divided quantities.

Reports of Medical Societies.

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY FRANCIS MINOT, M.D., SECRETARY.

Nov. 9th.—*Dropsy of the Fallopian Tubes and Ovaries.*—Dr. Ellis showed the specimen. The patient, an intemperate woman, 34 years old, had been married twelve years, and a widow for eight years, but had never become pregnant, although menstruation had, until late, been quite normal.

She entered the Hospital on the 12th ult., having suffered for three months with amenorrhœa and hæmaturia, with frequent micturition, hemicrania, constipation, thirst, occasional vomiting, and, on two occasions, copious epistaxis; and for three weeks with rather hard, paroxysmal cough. She was pale, weak and rather thin, with a small, frequent pulse. The urine was quite albuminous, and contained a few granular casts and considerable blood, but this last soon disappeared and did not return. She improved in many respects after entrance, but the cough continued to trouble her, and on the 19th ult. she had an attack of orthopnœa, with urgent, choking cough, mucous, bloody expectoration, and the physical signs of œdema or congestion of the lungs. More severe and prolonged attacks followed, and the patient finally died on the 6th inst. Œdema of the lower extremities had been noticed the last week of life, and three days before death there was a double friction-sound over the heart, with increased dulness on percussion. At this time the abdominal tumors were detected, the duration of which is entirely uncertain.

On opening the abdomen, two large bluish cysts were seen projecting up from the pelvis into the abdomen. They lay beneath the peritoneum, by which they were confined. That on the left side had pushed the sigmoid flexure upwards. The rectum lay between the two. They measured perhaps six inches in diameter, had very thin walls, and were apparently filled with serum. The Fallopian tubes gradually enlarged after leaving the uterus, became more or less tortuous, and finally terminated in the sacs; pressure upon the latter rendered the tubes tense. No ovaries were seen.

The kidneys were quite small, their cortical substance mottled, granular and thin. On microscopic examination, but very few tubuli were seen, and these appeared shrunken and deformed. Some free fat was seen, but none within the tubuli. There was a much larger amount of fibrous tissue than usual.

The lungs were œdematous. The upper part of the right one was congested. The right pleural cavity contained nearly a pint of serum.

There was recent pericarditis, and general hypertrophy and dilatation of the heart, which weighed one pound and one ounce.

Dr. Ellis remarked that Gross, in his Pathological Anatomy, says, "De Haen relates an instance in which the tube weighed seven pounds, and the cavity contained nearly four gallons of fluid; and a still more extraordinary one has been detailed by Mme. Boivin."

Nov. 23d.—*Dislocation of the Hip, in a Female.*—Dr. Cabot reported the following case:—

An Irish woman, 36 years old, was brought to the Hospital, Nov. 18th. She stated that as she was descending a flight of stairs, with a pail of water in each hand, she slipped upon a piece of apple-peel, and fell down the entire flight, bumping on several stairs as she went, and striking upon her left hip on the landing below. She was unable to rise without assistance, and was confined to her bed ever since. The accident occurred twenty-five days previously, no treatment having been adopted in the interval. Her condition at entrance was as follows:—she was in bed, the left leg flexed, the knee very much inverted, and resting across the right thigh just above the right knee. There was tenderness on pressure about the left hip and groin, and the slightest attempt to rotate or flex the thigh caused pain. Eversion and abduction of the thigh were not possible. The left trochanter was less prominent than the other, and higher up. The head of the femur was felt on the dorsum of the ilium. When the patient stood up the inversion was very marked, much more so than in dislocation on the dorsum in male subjects.

November 21st, twenty-eight days after the accident, the patient was etherized, and the dislocation was made out to be dorsal, with the head of the femur probably under the obturator muscle. An attempt at reduction was made by the flexion method, so called. A snap was heard, and the head of the bone was found to be below the socket. By reversing the manœuvre by which the head of the bone passed below the socket, it was carried directly behind the latter, and, the leg and thigh being flexed, and force applied in such a way as to lift it upwards, a slight manœuvre was sufficient to throw it into the socket, where it remained, with the limb in a nearly normal position. The movements of the leg were perfect; the thigh remained slightly flexed upon the body, owing to the permanent contraction of the muscles of the thigh and pelvis. The knees were tied together, with a cushion between them, and the patient was put to bed. There was a moderate amount of pain and soreness after the operation—much less than would have been expected. The patient was allowed to sit up for the first time Dec. 10th, and was free from pain and soreness.

Dr. Cabot said that Dr. Woodward, of Quincy, had seen two cases of dislocation of the hip in females, and at Dr. C.'s request had furnished him with the following account of them:—

"Quincy, Dec. 12th, 1863.

"Dear Sir,—In conversation with you on dislocation of the hip-joint, I observed to you that I had seen two cases of that accident in females. As the accident to females is so rare, you requested me to relate the cases to you, so far as my memory would serve me.

"The first case occurred fifteen or more years ago, and I shall not be able to state all the minute points of the case, but I think I can give you symptoms enough to satisfy you that it really was a dislocation, and not a fracture. A woman, between fifty and sixty years of age, as I should judge, was riding in an open wagon through Quincy. The horse took fright, and threw her from the wagon into the street. She was taken up, and carried into a house, and I was sent for. I found that she was unable to move her left leg; that the limb was shorter than the other, and that I was unable to rotate or elongate it. The direction of the foot I do not at present recollect. Being uncertain what the accident might be, I sent for Dr. Ware, of Milton, who concluded with me that it was a dislocation of the hip-joint upwards. We accordingly proceeded to set the bone, which, with the assistance of two or three strong men, we succeeded in doing. The limb became in length equal to its fellow, and remained so, by simply tying the ankles together with a handkerchief. Some inflammation took place, which required depletion, and the woman was removed in eight or ten days to her home without any inconvenience."

"The second case is of a lady, now residing here, who fell, some years ago, from the cellar stairs sideways, while reaching for something, to the bottom of the cellar, on her hip. She was forty-eight years of age. I found her removed to her bed, with her right limb shortened, and the foot turned outwards. By extension I could not restore the natural length of the limb. Before I dressed the leg, or attempted to replace it, she requested me to consult her friend Dr. A., of your city, who accordingly visited her, and after examination concluded that there was a dislocation on the pubis. But so doubtful was the case, that no attempt to replace the limb was made that evening. On the following morning I visited her alone, applied Jarvis's adjuster, replaced the limb, and tied the ankles together. The next morning, when Dr. A. visited her with me, he said that the bones were now in their right place. Considerable fever ensued, and the woman, although the limbs are of equal length, still limps, from some injury done to the socket I presume. From the symptoms related above, I think we must conclude that dislocation of the hip-bone took place in both these cases. Your friend,

"To S. Cabot, M.D., Boston. E. Woodward."

The Secretary stated that Dr. John O. Stone, of New York, had met with a case of dislocation of the hip in a female. The following account of the case was kindly furnished by Dr. Stone, and was read at the subsequent meeting:—

"New York, Nov. 27th, 1863.

"My dear Doctor,—The case you allude to was simply as follows:—During the month of September, 1842, I was attracted by an accident in Broadway. A woman in crossing this street was knocked down by an omnibus. It was evening. She could give no account of the accident, *how* she fell, *where* the omnibus struck her, or in what *position* the thigh was when she met with the accident. She could not walk: the left foot was turned outwards: the knees separated from each other, and the head of the left thigh was felt upon the pubes. I sent her home, and having procured pulleys, visited her at her residence, where I made a more particular examination. The head of the bone could be felt upon the pubes, but the limb was *longer* than the other by a half inch, and when she was raised in the erect position the heel of the dislocated limb touched the ground. In order to investigate these contradictory phenomena, I had her held in the erect position by two assistants. On rotating the limb inwards, the head of the bone moved downwards. On repeating this movement, the head of the bone slipped into its place.

"I then found that my patient had fainted, and that it was during this fortunate occurrence that the dislocation had been restored. The fainting was complete, and continued for twenty minutes after the reduction.

"I was still in doubt as to what it was that caused the dislocated limb to be longer than the other. I then learned that she always limped with the left limb, and that when a child she had had the rickets. Very truly yours, JOHN O. STONE."

"To FRANCIS MINOT, M.D., Boston.

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON: THURSDAY, DECEMBER 24, 1863.

HUXLEY *versus* OWEN.—The following burlesque, first published in the London *Times*, respecting the ethnological controversy which is at present attracting so much of the attention of the scientific men of Europe, and of which we have spoken in former numbers, is so very amusing that we copy it for the entertainment of those who may not have already seen it.

A *Sad Case—Mansion House—April* 23, 1863—(*Before the Lord Mayor*).

T. H. Huxley, well known about the town in connection with monkeys, and Richard Owen, in the old bone and bird-stuffing line, were charged by policeman X. with causing a disturbance in the streets.

The prisoners exchanged glances of such a character that it was thought prudent to keep them separated in the dock.

Policeman X., being sworn, stated as follows:—My attention was called to the prisoners by a crowd of persons, who seemed much excited—they appeared to take sides, and some were for Owen and some for Huxley. On coming near I saw Huxley snapping his fingers at Owen, and telling him he was only a little better than an ape; he seemed very angry, and would have done Owen some bodily harm if I had not been near. He told Owen he had quite as much brains as he had, and he called him some awful names. Must I repeat the bad words, your worship?

Lord Mayor—Certainly. You *must* state what he said.

Policeman X.—Well, your worship, Huxley called Owen a lying Orthognathus Brachycephalic Bimanous Pithecus; and Owen told him he was nothing else but a thorough Archencephalic Primate.

Lord Mayor—Are you sure you heard this awful language?

Policeman X.—Yes, your worship, and some more I could not exactly understand.

Lord Mayor—Did you see any violence used?

Policeman X.—Yes, your worship. Huxley had got a beast of a monkey, and he tried to make it tread on Owen's heels—and said 'twas his grandfather—and like him—and just the same breed and all that; and some gentlemen cheered and said "Bravo."

Lord Mayor—Did you see the man Huxley actually put the monkey on the other prisoner—was there no interval between them?

Policeman X.—He put the beast so near as ever he could; he tried to make him go quite close, but he could not, and he kept singing out, "Look at 'em, a'nt they like as peas?"

Lord Mayor—Did Owen appear much annoyed by this outrage?

Policeman X.—He behaved uncommon plucky, though his heart seemed broke. He tried to give Huxley as good as he gave, but he could not, and some people cried "Shame," and "He's had enough," and so on. Never saw a man so mauled before. 'Twas the monkey that worritted him, and Huxley's crying out, "There they are—bone for bone, tooth for tooth, foot for foot, and their brains one as good as t'other."

Lord Mayor—That was certainly a great insult.

Huxley—So they are, my lord, I can show—

Here a scene of indescribable confusion occurred. Owen loudly contradicted Huxley; the lie was given from one to the other; each tried to talk the other down; the order "Silence!" was unheeded; and for a time nothing could be heard but intemperate language, mingled with shouts of "Posterior Cornu," "Hippocampus," "Third Lobe," &c. &c. When order was restored, the Lord Mayor stated that, in all his experience, he had never witnessed such virulent animosity among costermongers.

The Lord Mayor here asked whether either party were known to the police.

Policeman X.—Huxley, your worship, I take to be a young hand, but very vicious; but Owen I have seen before. He got into trouble with an old bone man, called Mantell, who never could be off complaining as Owen prigged his bones. People did say that the old man never got over it, and Owen worritted him to death; but I don't think it was so bad as that. Hears as Owen takes the chair at a crib in Bloomsbury. I don't think it be a harmonic meeting altogether. And Huxley hangs out in Jermyn street.

Lord Mayor—Do you know any of their associates?

Policeman X.—I have heard that Hooker, who travels in the green and vegetable line, pats Huxley on the back a good deal; and Lyell, the resurrectionist, and some others who keep dark at present, are pals of Huxley's.

Lord Mayor—Lyell, Lyell; surely I have heard that name before.

Policeman X.—Very like you may, your worship; there's a fight getting up between him an' Falconer, the old bone man, with Prestwitch, the gravel sifter, for backer.

Owen—He's as bad as any of 'em, my lord. I thought he was a friend of mine, but he's been saying things of me as I don't like; but I'll be even with him some day.

Lord Mayor—Silence! Have you seen the prisoners in the company of any ticket-of-leave men?

Policeman X.—No, your worship; but from information I have received, I believe Huxley is one of the same set with John William Natal, or some such a name, for he is one of those chaps as has got a lot of aliases, who has lately returned from abroad. John's been kicking up a pretty row, he has.

Lord Mayor—I desire you to bring him before me if you detect him in creating any disturbances.

Policeman X.—Oh! your worship, there's plenty trying to catch him, but he's so artful they can't trap him no how. They wanted to take his ticket from him, but they could not; then they tried to coax him to give it up, but he would not; not he. You see when he was across the water, he took to the bush and got in with the savages, and tried to come over them, but one of the Kaffirs gave him such a topper that he's never been the same man since.

Lord Mayor—You have not seen them together?

Policeman X.—No, your worship; but I believe they are both tarred with the same brush.

As there appeared to be no case against Owen, he was allowed to be sworn. Hereupon Huxley demanded to be sworn likewise, but Owen objected, declaring it impossible to swear a man who did not believe in anything, and Huxley declared it was equally impossible to swear Owen. Owen, however, was directed to take the book in his hand, whereupon Huxley vociferated, "He does not know a hand from a foot." An angry altercation ensued between the parties, amidst the din of which the words "peronæus longus," "movable toe," "thumb," "astragalus," and "short flexor," could be distinguished. The Lord Mayor addressed both parties, and declared such violent conduct was scarcely human, at which Huxley laughed and Owen looked grave. He then gave his evidence as follows:—

I knew the prisoner in former years. We were both in the same business, and I looked upon him as a quiet, well-meaning man. But since he has risen in the world, he has become highly dangerous, so much so, that I am willing to believe his conduct proceeds from diseased brain.

Here the Mayor called upon Dick Owen to come at once to the point.

Owen proceeded—For the last two years my life has been a burden to me. That fellow Huxley has got new pals, Charlie Darwin, the pigeon-fancier, and Rollstone, and others of that awful lot; and he waylays me in public, and throws dirt at me. Indeed, he has hit me very much about the head, very hard indeed; and he tries to make believe that I don't know my trade; and that he can teach me; and he tries to make me ridiculous in the eyes of the public, and I can't bear it. And lately I went down to Cambridge, and who should I see there but that Tom Huxley and his low set, and they all attacked me at once—

[Here the Mayor directed the witness to keep to the point.]

Owen continued—I could live well enough, if you could only keep that beastly monkey away from me, and make Huxley hold his tongue about comparing our brains. Indeed, continued Owen, how would you like to be told in public that physically, morally and intellectually you were only a little better than a gorilla?

Huxley was now called upon, and said as follows:—

Me and Dick is in the same line—old bones, bird-skins, offal, and what not.

The Mayor—Do you mean the marine store line?

Huxley—No, your worship; that's Bowerbank and Woodward's business. Well, as I was saying, we was in the same line, and comfortable as long as Dick Owen was top-sawyer, and could keep over my head, and throw his dust down in my eyes. There was only two or three in our trade, and it was not very profitable; but that was no reason why I should be called a liar by an improved gorilla, like that fellow.

[Here the Mayor cautioned the prisoner.]

Well, in my business I put up monkeys, and the last monkey I put up was Dick Owen's.

[Here the Mayor declared, on the repetition of such language, he would at once commit Huxley.]

Well, as I was saying, Owen and me is in the same trade; and we both cuts up monkeys, and I finds something in the brains of 'em. Hallo! says I, here's a hippocampus. No there ain't, says Owen. Look here, says I. I can't see it, says he; and he sets to worriting and haggling about it, and goes and tells everybody as what I finds ain't there, and what he finds is, and that's what no tradesman will stand. So when we meets we has words. He will stick to his story, your worship, he won't be right himself, nor let any body else be right. As to this here monkey business, I can't help the brutes treading on his heels. If he was to go forward more, why you see he'd be further off from the beast; but he's one of these here standstill Tories, what they call the orthodox lot, as never moves forward. If he'll keep his tongue in his head, why I'll keep mine; but he shan't have the last word, or my name's not Tom Huxley.

[The Lord Mayor having tendered advice to the disputants, they were liberated.]

VITAL STATISTICS OF BOSTON.

For the Week ending Saturday, December 19th, 1863.

DEATHS.

	Males.	*Females.*	*Total.*
Deaths during the week - - - - - - - -	46	58	104
Ave. mortality of corresponding weeks for ten years, 1853—1863,	38.2	37.9	76.1
Average corrected to increased population - - - - -	00	00	83.28
Death of persons above 90 - - - - - - - - -	0	0	0

Mortality from Prevailing Diseases.

Phthisis.	Croup.	Scar. Fev.	Pneumon.	Variola.	Dysentery.	Typ. Fever.	Chol. Infan.
18	10	6	8	0	0	2	1

Books Received.—The Medical Formulary. By Benj. Ellis, M.D. 11th Edition. Philadelphia: Blanchard & Lea.—Synopsis of the Lectures on Materia Medica and Pharmacy delivered in the University of Philadelphia, &c. By Joseph Carson, M.D. 3d Edition. Philadelphia: Blanchard & Lea.—Asthma; its Pathology and Treatment. By Henry Hyde Salter, M.D., F.R.S. Philadelphia: Blanchard & Lea.

Died,—At Holliston, 17th inst., of congestion of the lungs, Timothy Fiske, A.M., M.D., aged 85 years.—At Salem, 21st inst., Richard H. Wheatland, M.D., 33 years.

Deaths in Boston for the week ending Saturday noon, Dec. 19th, 104. Males, 46—Females, 58.—Accident, 1—anaemia, 3—apoplexy, 1—asthma, 1—inflammation of the bowels, 1—congestion of the brain, 3—disease of the brain, 1—inflammation of the brain, 1—bronchitis, 4—cancer, 2—cholera infantum, 1—consumption, 18—convulsions, 3—croup, 10—dedility, 1—diarrhœa, 2—diphtheria, 2—dropsy, 4—dropsy of the brain, 4—scarlet fever, 6—typhoid fever, 2—gangrene, 1—gastritis, 1—hæmorrhage (uterine), 1—disease of the heart, 3—disease of the kidneys, 1—congestion of the lungs, 4—disease of the lungs, 2—inflammation of the lungs, 8—marasmus, 1—old age, 3—paralysis, 1—pleurisy, 2—unknown, 4—whooping cough, 1.

Under 5 years of age, 35—between 5 and 20 years, 11—between 20 and 40 years, 17—between 40 and 60 years, 27—above 60 years, 14. Born in the United States, 69—Ireland, 25—other places, 10.